Infliximab Infusion Referral Form

University Hospitals Home Care Services

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Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Info.

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐ **M** ☐ **F**

Address: _____

Phone: _____ **2nd Phone:** _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (Include ICD-10 Code): _____

Weight:_____ ☐lb ☐kg **Height:**_____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Patient's first dose of Infliximab? ☐Yes ☐No (If no, date of last dose: _____ Prior dose (in mg): _____)

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

Date of *negative* TB test: _____ ☐TB test pending, will fax results. **Patient is HBV negative or has been treated:** ☐Yes ☐No

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No **Smoker?** ☐Yes ☐No

In the past year: Use of corticosteroids: ☐Yes ☐No Use of narcotics: ☐Yes ☐No Presence of psychiatric illness: ☐Yes ☐No

Number of IBD-related hospitalizations in the past year: _____ Minimal hemoglobin value (g/dL) in the past year: _____

Referring provider's preferred site of care: ☐Home Care Infusion Center ☐Home Infusion ☐Home Care to determine site of care
Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Prescription Information

Product Selection:
Specific infliximab brand requested: _____
(If no brand indicated, pharmacist to select infliximab brand based on clinical judgement, payer coverage, and cost to patient.)

Infliximab dose: ☐3mg/kg ☐5mg/kg ☐7.5mg/kg ☐10mg/kg in 250mL NaCl 0.9% infused over not less than 2 hours.
Based on the clinical judgement of the pharmacist, doses may be rounded up or down to the nearest vial size (100mg) unless checked here: ☐
Supply Items: Must be infused through infusion set containing a sterile, non-pyrogenic, low-protein-binding filter with pore size ≤ 1.2µm.

Dosing Regimen	Quantity
☐**Induction Dosing:** Infuse at 0, 2, and 6 weeks, then begin maintenance dosing.	3 doses (infusions)
☐**Maintenance Dosing:** Infuse every ☐8 weeks ☐6 weeks ☐4 weeks ☐Other: _____	_____ doses (infusions)

Premedication(s):
☐Acetaminophen 325-650mg PO 15-30 minutes prior to infusion ☐Diphenhydramine 25-50mg PO 15-30 minutes prior to infusion
☐Other premedication(s): _____

PRN Medication(s):
☐Acetaminophen 325-650mg PO Q4 hours PRN ☐Diphenhydramine 50mg IV x1 dose PRN ☐Methylprednisolone 125mg IV x1 dose PRN
☐Other PRN medication(s): _____

Laboratory orders (subject to availability): _____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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